back of the neck, which the patient described as "severe," developed. The patient was discharged from the hospital as improved, although no treatment had been given; the pain in the lower back was considered not due to organic disease.

Five days after the myelographic examination, the patient became aware of diplopia and he became dizzy and nauseated. Examination of the eyes showed normal acuity of vision in both. A cover test showed esotropia of 8 diopters at 6 meters and exophoria of 4 diopters at 33 centimeters. A motility test showed the external rectus muscle of the right eye to be paretic. The fundi were normal. A patch was worn over the right eye for two weeks and at the end of that time the acuity of the right eye was 20/25; of the left, 20/25. There was esotropia of 15 diopters at 6 meters and right hypertropia of 4 diopters at the same distance. Three months after onset, diplopia suddenly ceased, and two weeks later all evidence of extraocular muscle weakness disappeared. At that time there was again normal acuity of vision in both eyes, and a cover test showed orthophoria at 6 meters. At 33 centimeters there was exophoria of 6 diopters. Motility was normal. The near point of convergence was at 100 mm.

COMMENT

The symptoms in this case remarkably resembled those of abducens paralysis following spinal anesthesia. The delayed onset, spontaneous recovery and solitary abducens palsy were typical of the circumstances reported for that condition.

SUMMARY

A case of extraocular muscle paralysis following myelography with Pantopaque is reported. Spontaneous recovery occurred with conservative treatment.

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Foreign Bodies in the Rectum Simulating Anorectal Disease

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THE classical symptoms of anorectal disease such as pain, pressure, protrusion, bleeding, and alteration of bowel habit are familiar to all physicians.

These symptoms may also be produced by foreign bodies lodged within the terminal portion of the alimentary canal, thus simulating anorectal disorders more commonly encountered in proctologic practice. According to Bacon[1] there are four routes by which a foreign body may enter the rectum. These are: By ingestion and normal passage to its terminus; through development within the intestinal tract; by entry from a neighboring organ; and finally by insertion through the anus. Obviously, entry through either the upper or lower orifice of the alimentary tract is the most common. Many bizarre foreign bodies have been reported in the literature[2] and it is not necessary to detail them here.

The following case reports are offered to illustrate the mimicry of anorectal disease by the presence of these objects, to demonstrate the advisability of considering foreign body in the evaluation of proctologic complaints, and lastly to show how readily diagnosis may be made if the patient is examined and not merely given a suppository and a word of reassurance. The presence of a foreign body was suspected in only one of the four cases—Case 4—and then only because of the patient's manner while giving the history.

CASE REPORTS

Case 1: A 75-year-old white man entered the office complaining of severe anal pain of sharp character aggravated by stool and following stool for the preceding four days. An occasional streak of blood had been noted on the toilet tissue. Inspection of the anal area disclosed no abnormality. The sphincter was tightly contracted. Upon digital examination a sharp, hard object lodged just above the internal sphincter was noted. This was extracted and proved to be a fragment of bone an inch long and one-half inch wide. The patient, who wore dentures, surmised that it had been ingested with lamb stew eaten several days previously. Proctoscopic findings were normal.

Case 2: A 63-year-old white man reported with the complaint of painful protrusion from the anus of two days' duration which had appeared suddenly after stool and could not be reduced. Usual palliative remedies had afforded no relief. Inspection of the anus revealed a spicule of bone protruding from the orifice. The fragment was removed and found to be a thin lance-shaped bone measuring 1¼ by ½ inches. The patient, who wore dentures, said that he probably had swallowed the bone while eating ground chicken several days previously. Proctoscopic findings were normal.

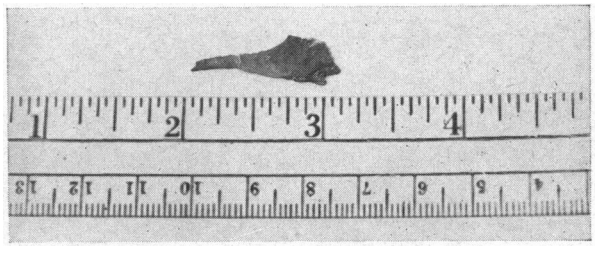

Figure 1.—Chicken bone fragment removed from the anus that caused severe pain and bleeding.

CASE 3: A 43-year-old obese white woman weighing well over 300 pounds sought consultation because of progressive constipation of four months' duration and a sense of pressure within the rectum. There was no history of pain, bleeding or protrusion. Inspection and digital examination disclosed no abnormality. Proctoscopy demonstrated a huge fecal impaction high in the rectum. This was removed. Subsequent examination disclosed no abnormality.

CASE 4: A 65-year-old white man was referred by another physician because of sudden change in bowel habit with severe constipation of one week's duration which had persisted despite many laxatives. Inspection of the anus demonstrated no abnormality. Upon introducing the finger a hard movable mass could be felt. With the introduction of a large anoscope a feces-covered stick was visualized with one end impinged against the lowest valve of Houston. A Kocher clamp was inserted, the stick was grasped and elevated and, along with the anoscope, withdrawn from the lower bowel. The stick was a piece of tree branch an inch in diameter and ten inches long, sharpened on one end and blunt at the other. Questioning elicited that one week previously, while drunk, the patient had been induced to insert the stick into his rectum and had not been able to retrieve it. Proctoscopic examination at the time demonstrated severe mucosal ulceration one inch in diameter where the foreign body had lodged against the anterior surface of the rectum. The patient was instructed to return for reexamination, but did not keep his appointment.

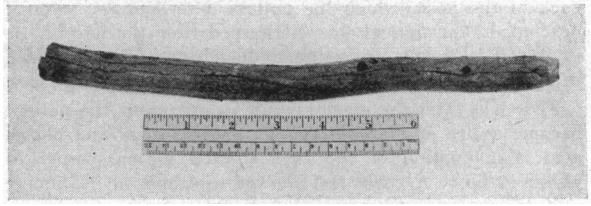

Figure 2.—Stick removed from the rectum and sigmoid that produced sudden change in bowel habit.

SUMMARY

Foreign bodies lodged within the rectum may mimic any of the well known symptoms of anorectal disease, but their presence may be readily diagnosed by examination.

Instances of the lodgement of foreign bodies within the terminal part of the alimentary canal by ingestion, formation within the intestinal tract, and by introduction through the anus are presented. Symptoms were indistinguishable from those produced by true anorectal disease.

Elderly wearers of dentures may ingest foreign bodies unknowingly. Both patients who swallowed bone fragments were in this category.

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